

Tampa Bay Hypno-Therapy LLC / Tamera L. Fontenot, LMHC, NCC  
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*This is a strictly confidential medical record. Re-disclosure or transfer is expressly governed by law.*

Date: \_\_\_\_\_

Name: \_\_\_\_\_, Date of Birth \_\_\_\_\_

Address: \_\_\_\_\_ City/State \_\_\_\_\_ Zip \_\_\_\_\_

Phone: \_\_\_\_\_ Can messages be left at this number? \_\_\_\_\_

Would you like to receive appointment reminders and emailed communications?

Email \_\_\_\_\_

(please know that electronic communications have limited confidentiality)

Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone: \_\_\_\_\_

How did you find us? \_\_\_\_\_

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1) Have you ever participated in any counseling, psychological or psychiatric services before? \_\_\_\_\_.

2) Please list any current medications or treatments you are receiving, current health concerns: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

3) Have you been/are you currently involved in any legal proceedings at this time (i.e. custody disputes, divorce, litigation with any party, etc.) \_\_\_\_\_. If yes, do you intend for your records to be shared? \_\_\_\_\_

4) Do you, or do others, think you have a problem with drugs, alcohol or other substances? \_\_\_\_\_. If yes, please explain \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

5) Have you, or are you currently, experiencing thoughts of suicide or of harming other persons? \_\_\_\_\_

6) What seems to be the problem, why are you here today? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

7) 6 months from now, how do you want things to be different? Be specific, how will YOU know that things have improved? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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- 8) Do you have sleep difficulties?  
 Rarely  
 I don't get enough sleep  
 I have trouble falling asleep  
 I have trouble staying asleep  
 I sleep too much

- 9) Eating Patterns:  
 I am on a special diet - Specify: \_\_\_\_\_  
 I eat mostly healthy foods  
 I don't eat regularly       I overeat  
 I purge myself when full       I binge eat  
 I do not eat enough       I snack too often

- 10) Exercise Patterns:  
 I work out frequently  
 I exercise occasionally  
 I do not get enough exercise  
 I have a health condition that limits my ability to exercise - Specify \_\_\_\_\_

- 11) In my social life, I am:  
 Unsatisfied  
 Sometimes satisfied  
 Mostly satisfied  
 Very satisfied

- 12) In my personal relationships, I am:  
 Unsatisfied  
 Sometimes satisfied  
 Mostly satisfied  
 Very satisfied

- 13) In my work, education or career, I am  
 Unsatisfied  
 Sometimes satisfied  
 Mostly satisfied  
 Very satisfied

14) How do you currently handle tension and stress? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

15) What do you do for fun? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

16) What are your hobbies/special interest? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

17) List 5 personal strengths: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I have accurately provided the above background information as requested by the counselor.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date